

CITY OF HAMPTON
Request for Disability Related Accommodations
Annual/Periodic Review of Reasonable Accommodations

Employee Name	Employee Number	Date of Request
Department	Division	Department Head Name

Date Original Request for Accommodation Approved: _____

Date of Periodic Review: _____

After a review of the employee's Request For Reasonable Accommodation file, the following has been determined:

☐ New/Additional medical/diagnostic documentation is **not** required to continue the accommodation.

☐ Additional Medical/Diagnostic documentation is required.

☐ Other _____

The Approving Authority is requesting the following documentation:

Approving Authority

Name and Title of Approving Authority: _____

Continuation of reasonable accommodation: (*Check one*) ☐ Approved ☐ Disapproved (If disapproved, attach a copy of the written memo stating reason.

Department Head Signature: _____ Date: _____

Human Resources Representative Signature: _____ Date: _____